Evidence of Coverage

Effective January 01, 2006 – December 31, 2006

Preferred Provider Plan

PERSCare

Supplement to Original Medicare Plan

CalPERS

HOW TO REACH US

Important: For all members outside of the United States, contact the operator in the country you are in to assist you in making a toll-free number call.

CUSTOMER SERVICE

For medical claims status, benefit information, identification cards, booklets, or claim forms, call:

Customer Service Department
Blue Cross of California
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)
1-818-234-3547 (TDD)
Web site: www.bluecrossca.com

MEDICAL CLAIMS AND CORRESPONDENCE

Please mail your medical claims and correspondence to:

PERSCare Health Plan
Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

PRESCRIPTION DRUG PROGRAM

For information regarding the Retail Pharmacy Program or Mail Service Program, call:

Caremark Inc.
1-866-999-7377 (U.S., Canada and Mexico)
1-210-403-8288 (International)
Web site: www.caremark.com

ELIGIBILITY AND ENROLLMENT

For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the CalPERS Office of Employer and Member Health Services (retirees). You also may write:

Office of Employer and Member Health Services
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

Or call:

(888) CalPERS (225-7377)
(916) 795-3240 (TDD)

MEDCALL

Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. You can reach a specially trained registered nurse who can address your health care questions by calling MedCall at 1-800-700-9185. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week. Be prepared to provide your name, the patient's name (if you're not calling for yourself), the subscriber's identification number, and the patient's phone number.

ADDRESS CHANGE

Active Employees: To report an address change, active employees should complete and submit the proper form to their employing agency's personnel office.

Retirees: To report an address change, retirees may contact CalPERS by phone at (888) CalPERS (225-7377), on-line at www.calpers.ca.gov, or submit a signed written notification, including identification number, new address, and other pertinent information, to:

Office of Employer and Member Health Services
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

PERSCare MEMBERSHIP DEPARTMENT

For direct payment of premiums, contact:

PERSCare Membership Department
Blue Cross of California
P.O. Box 629
Woodland Hills, CA 91365-0629
1-877-737-7776
1-818-234-5141
(outside the continental U.S.)

PERSCare WEB SITE

Visit our Web site at:

www.calpers.ca.gov

IMPORTANT INFORMATION

No person has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the Benefits After Termination or Continuation of Coverage provisions in this booklet.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect, and while the benefits you are claiming are actually covered by this Plan.

Reimbursement may be limited during the term of this Plan as specifically provided under the terms in this booklet. Benefits may be modified or eliminated upon subsequent years' renewals of this Plan. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

MedCall

Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. You can reach a specially trained registered nurse who can address your health care questions by calling MedCall toll free at **1-800-700-9185**. If you are outside of the United States, you should contact the operator in the country you are in to assist you in making the call. Be prepared to provide your name, the patient's name (if you are not calling for yourself), the subscriber's identification number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs.* Based on the information you provide, the advice may be to:

- Take care of yourself at home. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your physician. If you do not have a physician, the nurse will help you select one by providing a list of physicians who are Preferred Providers in your geographical area.
- Call your physician for further discussion and assessment.
- Immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library, featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 1-800-700-9185 and follow the instructions given.

* Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your physician's care.

TABLE OF CONTENTS

BENEFIT AND ADMINISTRATIVE CHANGES

There are no benefit and administrative changes effective January 1, 2006.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

This is only a summary of Plan benefits. See page 12 for a detailed description of how Supplement to Original Medicare Benefits are paid by the PERSCare Plan and the Outpatient Prescription Drug Program section beginning on page 16. Payments applicable to Benefits Beyond Medicare are described on page 14. Please review this booklet and *Medicare & You* (the handbook describing Medicare benefits) for specific information on benefits and exclusions.

Benefit Category	Medicare Pays	Member Pays
Hospital		
Inpatient and Outpatient	See Medicare Handbook	No charge — If Medicare-approved.*†
Physician/Preventive Care		
Office/Home/Hospital Visits	See Medicare Handbook	No charge — If Medicare-approved.*
Gynecological Exam (Pap test)	See Medicare Handbook	No charge — If Medicare-approved.*
Allergy Testing/Treatment	See Medicare Handbook	No charge — If Medicare-approved.*
Immunization/Inoculation	See Medicare Handbook	No charge — If Medicare-approved.*†
Hearing Aid Services	See Medicare Handbook	20%.†
Diagnostic X-Ray/Laboratory	See Medicare Handbook	No charge — If Medicare-approved.*
Ambulance	See Medicare Handbook	No charge — If Medicare-approved.*
Emergency Care/Services Under certain conditions, Medicare helps pay for emergency outpatient care received from non-participating hospitals.	See Medicare Handbook	No charge — If Medicare-approved.*
Mental Health		
Inpatient	See Medicare Handbook	No charge — If Medicare-approved.*†
Outpatient	See Medicare Handbook	Excess charges.*† (Medicare pays 50% of the approved amount for most services.)
Home Health Services Medically necessary services obtained through a licensed home health agency.	See Medicare Handbook	No charge — If Medicare-approved.*

* If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full. However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by PERSCare and Medicare. See page 12 for important information regarding Plan payments.

† This is a Benefit Beyond Medicare. When benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use a Blue Cross Preferred Provider. However, if you use a non-Preferred Provider, the Plan will pay 80% of the Allowed Amount as determined by Blue Cross and your responsibility will be 20% of the Allowed Amount and any charges in excess of the Allowed Amount. See page 14 for important information regarding Plan payments.

Benefit Category	Medicare Pays	Member Pays
Skilled Nursing Care Up to 100 days each benefit period in a Medicare-approved facility.	See Medicare Handbook	No charge — If Medicare-approved.*
From 101 to 365 days.		20%† (Must be precertified by Blue Cross – see page 11.)
Speech/Physical/ Occupational Therapy		
Speech	See Medicare Handbook	No charge — If Medicare-approved. † ($5,000 lifetime maximum per Member)
Physical	See Medicare Handbook	No charge — If Medicare-approved. †
Occupational	See Medicare Handbook	No charge — If Medicare-approved. †
Acupuncture/Biofeedback/ Chiropractic		
Acupuncture	See Medicare Handbook	20%† (20 visits per calendar year.)
Biofeedback	See Medicare Handbook	No charge — If Medicare-approved.*
Chiropractic	See Medicare Handbook	No charge — If Medicare-approved.*
Durable Medical Equipment	See Medicare Handbook	No charge — If Medicare-approved.*
Other		
Heart Transplants	See Medicare Handbook	No charge — If Medicare-approved.*
Kidney Dialysis and Transplants	See Medicare Handbook	No charge — If Medicare-approved.*
Hospice Care	See Medicare Handbook	No charge — If Medicare-approved.*
Podiatrists' Services	See Medicare Handbook	No charge — If Medicare-approved.*
Christian Science Treatment	See Medicare Handbook	No charge — If Medicare-approved.*
Unreplaced Blood and Blood Products	See Medicare Handbook	20%†

* If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full. However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by PERSCare and Medicare. See page 12 for important information regarding Plan payments.

† This is a Benefit Beyond Medicare. When benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use a Blue Cross Preferred Provider. However, if you use a non-Preferred Provider, the Plan will pay 80% of the Allowed Amount as determined by Blue Cross and your responsibility will be 20% of the Allowed Amount and any charges in excess of the Allowed Amount. See page 14 for important information regarding Plan payments.

Benefit Category	Medicare Pays	Member Pays
Diabetes Services Glucose monitors, test strips, lancets, etc.	See Medicare Handbook	No charge — If Medicare-approved.*†
Diabetes self-management training	See Medicare Handbook	No charge — If Medicare-approved.*
Prescription Drugs	Not Covered by Medicare	
Retail Pharmacy Program up to a 34-day supply		$5 generic $15 Preferred (On Caremark's Preferred Drug List) brand-name medications $45 Non-Preferred (Not on Caremark's Preferred Drug List) brand-name medications $30 for Medically Necessary waiver of Non-Preferred brand copay +
Maintenance medications**, if purchased at a retail pharmacy after 2nd fill		$10 generic $25 Preferred (On Caremark's Preferred Drug List) brand-name medications $75 Non-Preferred (Not on Caremark's Preferred Drug List) brand-name medications $45 for Medically Necessary waiver of Non-Preferred brand copay +
Mail Service Program Maintenance medications**, up to a 90-day supply.		$10 generic $25 Preferred (On Caremark's Preferred Drug List) brand-name medications $75 Non-Preferred (Not on Caremark's Preferred Drug List) brand-name medications $45 for Medically Necessary waiver of Non-Preferred brand copay + A $1,000 maximum copayment per person per calendar year applies.
**Maintenance medications are drugs that do not require frequent dosage adjustments, which are usually prescribed to treat a long-term condition, such as birth control, or a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days. Refer to the Outpatient Prescription Drug Program on page 16 for more information.		+ In order to obtain a waiver of the Non-Preferred Brand copay, you must request a waiver of the Non-Preferred Brand copay based on medical necessity through Caremark's formal appeals process outlined on page 41.

* If benefits are payable by Medicare and you use a provider who accepts Medicare assignment, covered services will be paid in full. However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by PERSCare and Medicare. See page 12 for important information regarding Plan payments.

† This is a Benefit Beyond Medicare. When benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use a Blue Cross Preferred Provider. However, if you use a non-Preferred Provider, the Plan will pay 80% of the Allowed Amount as determined by Blue Cross and your responsibility will be 20% of the Allowed Amount and any charges in excess of the Allowed Amount. See page 14 for important information regarding Plan payments.

Benefit Category	Medicare Pays	Member Pays
Vision Care One exam and two lenses per calendar year. One set of frames during a 24-month period. **Maximum Allowance** Exam.....$35 Frames.....$30 Each lens: Single Vision .....$20 Bifocal .....$35 Trifocal .....$45 Lenticular .....$50 Contact Lenses.....$100	Not Covered by Medicare	Any amount in excess of the Maximum Allowance

HOW TO USE THE PLAN

Welcome to PERSCare!

This Supplement to Original Medicare Plan is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. After you or your eligible family members are enrolled in this Plan, you may not change enrollment to a Basic Plan unless (1) there is an involuntary termination of your Medicare benefits, or (2) you move, other than temporarily, outside the United States as defined in the Federal Social Security Act. If you voluntarily cancel Part B of Medicare, you will not be eligible for a Basic Plan, nor will you be allowed to remain in this Plan.

A family group member, including a person enrolled in this Plan, who is not eligible for Medicare and continues in the PERSCare Basic Plan must enroll in this Plan when he or she is eligible to enroll in Medicare.

Please note that this Plan does not cover custodial care in any facility or situation, including a skilled nursing facility.

As a PERSCare Member, you are responsible for meeting the requirements of the Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance. So please take some time to become familiar with this booklet and *Medicare & You*.

Thank you for joining PERSCare.

Medicare & You

Each year the U.S. Department of Health and Human Services publishes a Medicare handbook entitled *Medicare & You*. This handbook outlines the benefits Medicare provides and includes any changes in deductibles, coinsurance, or benefits that may occur from year to year. To obtain a copy, contact your nearest Social Security office, visit the Web site www.medicare.gov or write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

A directory of physicians who accept Medicare assignment (Medicare Provider Directory) can also be obtained from the Department of Health and Human Services at the above address.

Please refer to page 12 of this booklet for a description of the difference in benefit payments using a provider who accepts Medicare assignment and a provider who does not accept Medicare assignment. It is your responsibility to confirm with your provider whether or not he or she accepts Medicare assignment prior to receiving services.

Some providers do not participate in Medicare. If you choose to get care from a provider who has decided not to participate in, or has been excluded from, the Medicare program, Medicare and this Plan will not pay for services provided by that provider. You will have to pay whatever the provider charges you for his or her services.

PERSCare Identification Card

As a PERSCare Member, you will receive a PERSCare ID card. Simply present this card to receive medical services and prescription drug benefits of the Plan. If you need a replacement card, call the Blue Cross Customer Service Department at 1-877-737-7776.

Possession of a PERSCare ID card confers no right to services or benefits of this Plan. To be entitled to services or benefits, the holder of the card must in fact be a Plan Member on whose behalf premiums have actually been paid.

If you allow the use of your ID card (whether intentionally or negligently) by an unauthorized individual, you will be responsible for all charges incurred for services received. Any other person receiving services or other benefits to which he or she is not entitled, without your consent or knowledge, is responsible for all charges incurred for such services or benefits.

Members Who Move Outside the United States

If you move, other than temporarily, outside the United States as defined in the Federal Social Security Act, you are no longer eligible for this Plan. You must change enrollment to a Basic Plan as Medicare does not provide benefits when you are permanently outside the United States. Please contact the Health Benefits Officer at your agency (active) or the CalPERS Office of Employer and Member Health Service (retirees) as soon as possible to enroll in a Basic Plan.

Claim-Free Service

As a PERSCare Supplement to Original Medicare Plan Member, you may enroll in a claims filing program called the *Claim-Free* program. Your enrollment in the *Claim-Free* program means that you need not file a paper claim yourself for Supplement to Original Medicare professional and hospital benefits as long as your provider billed Medicare directly.

NOTE: The *Claim-Free* program does not apply to the "Benefits Beyond Medicare" listed on pages 12 through 14. See page 8 for more information on how to obtain reimbursement for those benefits.

Once enrolled in the *Claim-Free* program, your Supplement to Original Medicare benefits will automatically be paid through Blue Cross of California's *Claim-Free* process, which makes it possible for Blue Cross plans to electronically obtain Medicare claims data directly from Medicare claims processors. In some cases, you may receive your PERSCare Supplement to Original Medicare benefit claim payment faster than your Medicare payment.

To enroll in the *Claim-Free* program, return the postcard that will be sent to you automatically once you are enrolled in the PERSCare Supplement to Original Medicare plan. You may also call Blue Cross at 1-877-737-7776 to enroll. Please make sure you have your Medicare card available when you place the call.

You may disenroll from the *Claim-Free* program for any reason by calling Blue Cross of California at 1-877-737-7776. Make sure you have your Medicare card available when you place the call. If you choose to disenroll in the Claim-Free program, you will need to submit your claims to Medicare as discussed below.

Supplement to Original Medicare Benefits

Hospital Benefits (Part A)

If you are not enrolled in the *Claim-Free* program, you should present your PERSCare ID card along with your Social Security Medicare ID card at the hospital admissions desk. The hospital may bill Blue Cross of California for benefits under your PERSCare Supplement to Original Medicare Plan after they have received payment from Medicare. You should discuss billing procedures with the hospital's billing office.

If you do not have your PERSCare ID card when you enter the hospital or if the status of your contract is questioned, ask the hospital to contact Blue Cross of California at 1-877-737-7776.

Medical Benefits (Part B)

If you are not enrolled in the *Claim-Free* program, you must first submit all medical claims to Medicare.

After Medicare has processed your claim, you will receive a Medicare Summary Notice statement. Write your member number and group number (from your PERSCare ID card) on the Medicare Summary Notice statement, then mail it and a copy of the itemized bill for the services received to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

Blue Cross of California will make supplemental payments as described under Description of Benefits beginning on page 12.

Payments for services covered by this Plan may be paid to you or directly to the provider if he or she is a Physician Member.

Outside the United States

Medicare does not provide benefits when you are outside the United States or its territories and need medical attention or hospitalization for illness or injury. Therefore, you should pay the bill yourself and submit a copy of the bill along with a report from the attending physician to Blue Cross. You will then be reimbursed for covered services by Blue Cross.

All claims should be submitted to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

Please refer to pages 14 and 15 for information regarding the benefits which will be provided along with information regarding exceptions that may apply to Canadian or Mexican hospitals.

For Prescription Drug Claims: There are no Participating Pharmacies outside of the United States. To receive reimbursement for outpatient prescription medications purchased outside the United States, complete a Caremark Prescription Drug Claim Form and mail the form along with your pharmacy receipt to Caremark at P.O. Box 686006, San Antonio, TX 78268-6006. Prescription medication covered by the Plan will be reimbursed at one hundred percent (100%), minus a forty-five dollar ($45) copayment for a 1-month supply, based on the foreign exchange rate on the date of service. **Claims must be submitted within twelve (12) months from the date of service.**

Benefits Beyond Medicare

Benefits for "Benefits Beyond Medicare" will be determined at the same time your Supplement to Original Medicare benefits are determined for services and supplies covered under both parts of the Plan.

To obtain reimbursement for those services and supplies that are a benefit only of your "Benefits Beyond Medicare" coverage, submit copies of your bills, properly identified, to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

No claim forms are necessary.

Bills submitted should include:

- The statement "Benefits Beyond Medicare"
- Subscriber's name
- Subscriber ID / Member number
- Group number
- Patient's name
- Patient's date of birth
- Patient's date of injury/illness
- The Medicare ID number & the Medicare effective date
- Date(s) of service
- Diagnosis
- Type(s) of service
- Provider's name & tax ID number
- Amount charged for each service
- Patient's other insurance information

Claims for benefits provided under "Benefits Beyond Medicare" must be submitted within fifteen (15) months after the date services were provided.

To receive reimbursement for **Vision Care Benefits,** refer to the following page for the mailing address and other information.

Claims Review for Benefits Beyond Medicare

PERSCare reserves the right to review all claims and medical records to determine whether any exclusions or limitations apply.

Vision Care Benefits

For California Residents

If you are a California resident, your routine vision care benefits are administered by Vision Service Plan (VSP). To receive maximum benefits under this Plan, make sure your vision care provider is a VSP participating provider. VSP providers have agreed to discounted fee arrangements which should reduce your out-of-pocket expenses. VSP participating providers will obtain an authorization number on your behalf and will submit claims to VSP after you have received services.

To locate a VSP participating provider near you, call VSP at 1-800-877-7195 or visit the Web site at www.vsp.com.

You are not restricted to using VSP providers. If you choose to receive services from a non-participating provider, you must pay the bill at the time you receive the services and then request reimbursement from VSP.

To obtain reimbursement directly from VSP, submit a copy of an itemized bill, listing the covered services and supplies you received, to:

VSP
Non-Member Doctor Claims
P.O. Box 997100
Sacramento, CA 95899-7100

For Members Residing Outside California

If you reside outside the state of California, vision care benefits will be provided as shown on page 15 for covered services and supplies received from any qualified vision care provider.

To obtain reimbursement for those services and supplies, submit copies of your itemized bills, properly identified, to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

Routine Vision Care Benefits - What Is Covered

The Vision Care Benefits described on page 15 are provided for *routine* vision care ONLY. Examples of covered services include *routine* eye examinations, refractions, pupil dilation, glasses and contact lenses. Examples of vision care services that are **not** considered *routine* include examinations for diagnosed medical conditions of the eye such as cataracts or glaucoma, and eyeglasses or contact lenses prescribed following cataract surgery.

To obtain reimbursement for the treatment of such non-routine medical conditions of the eye, you must first submit copies of your bills to Medicare for processing. After Medicare has paid its portion of the bill, submit a copy of the bill along with a copy of your Medicare Summary Notice to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

HOW TO USE THE PLAN

Request for Additional Information

A questionnaire will be sent to you annually regarding other health care coverage or Medicare coverage. A questionnaire regarding third-party liability will be sent to you following Blue Cross' receipt of any claim which appears to be the liability or legal responsibility of a third party. Your cooperation in returning the form promptly will provide Blue Cross with information necessary to process your claim. If another carrier has the primary responsibility for claims payment, submit a copy of the other carrier's Explanation of Benefits with the itemized bill from the provider of service. **Blue Cross cannot process your claim without this information.**

Payment to Providers—Assignment of Benefits

The benefits of this Plan will be paid directly to Preferred Providers and medical transportation providers. Also, Non-Preferred Providers and other providers of service will be paid directly when you assign benefits in writing.

UTILIZATION REVIEW

Utilization review is designed to involve you in an educational process which ensures that services are medically necessary, rendered in the most appropriate setting, and consistent with acceptable treatment patterns found in managed care environments. Blue Cross' Review Center reviews all skilled nursing facility stays for medical necessity after the first one hundred (100) days. The Plan may also request the Review Center's case managers to review other kinds of care for medical necessity.

Staff in the Review Center will work with you and your physician during a skilled nursing facility stay to assist you in receiving maximum benefit coverage and to minimize your out-of-pocket costs. The Review Center will continue to monitor care throughout the stay to help assure that quality medical care is efficiently delivered.

Payment will be denied if the Review Center determines that a skilled nursing facility stay is not medically necessary or that a lower level of care is more appropriate.

Case Management

The purpose of case management services is to assist you in obtaining high quality, cost-effective and medically necessary care. Currently, case management nurses in the Review Center review all skilled nursing facility stays after the first one hundred (100) days. The Member, the Member's physician or the Plan may also request that the Review Center perform case management services for other Members who will benefit from these services.

If Case Management services are requested for and accepted by a specific PERSCare Member, the Member will avoid higher out-of-pocket expenses by compliance and cooperation with the Review Center's Case Management services, even though the services under review may not be listed in the PERSCare Evidence of Coverage as needing the Review Center's review.

All services are subject to review for medical necessity by the Review Center for the patient in Case Management.

DESCRIPTION OF BENEFITS

Supplement to Original Medicare Benefits

Subject to benefits being covered by Medicare while you are enrolled under PERSCare, PERSCare will pay the amounts shown below under *Plan Payments* for medically necessary services and supplies furnished for the diagnosis or treatment of illness, pregnancy, or accidental injury. The date on which a service or supply is furnished will be deemed the date on which the expense was incurred or the charge made.

If you choose to get care from a provider who does not participate in the Medicare program, Medicare and this Plan will not pay for the services and supplies provided by that provider. You will have to pay whatever the provider charges you for his or her services. (For information on Medicare benefits, please refer to the *Medicare & You* handbook or call your nearest Social Security office.)

Payment of Supplement to Original Medicare Benefits

Deductibles

When a Member is receiving concurrent benefits from Medicare, PERSCare pays one hundred percent (100%) of the Medicare Part A and B deductibles.

Plan Payments

When a Member is receiving concurrent benefits from Medicare, PERSCare payments for covered charges are provided according to whether the provider accepts Medicare assignment. The following illustrates how PERSCare payments will be determined.

If the provider ***accepts Medicare*** *Assignment:*	*If the provider* ***DOES NOT accept Medicare*** *Assignment:*
The PERSCare payment is limited to one hundred percent (100%) of the difference between the amount paid by Medicare and Medicare's approved amount. See notes 1 and 2 below.	The PERSCare payment is limited to one hundred percent (100%) of the Medicare Limiting Amount (defined on page 48), less the amount paid by Medicare for covered charges. See notes 1 and 3 below.

NOTES:

1. The PERSCare payment plus the Medicare payment will be accepted as payment in full by Blue Cross Physician Members whether they accept Medicare assignment or not.
2. The PERSCare payment plus the Medicare payment will be accepted as payment in full by providers who are not Blue Cross Physician Members but who **DO** accept Medicare assignment.
3. Plan Members will be responsible for the difference between the amount paid by PERSCare and Medicare and the charges billed by providers who are not Blue Cross Physician Members and who do not accept Medicare assignment, within the limits of applicable law.

Benefits Beyond Medicare

PERSCare will provide the following coverage for medically necessary services and supplies when a Plan Member's benefits under Medicare are exhausted, or when charges for the services and supplies outlined in this section exceed amounts covered by Medicare:

1. **Inpatient and outpatient hospital services and supplies**
   (mental health benefits are described separately below).
2. **Semi-private room charges for skilled nursing facility stays, instead of hospitalization, from the 101st through the 365th day during each benefit period.** An additional 265 days will not be approved unless a new benefit period has been established by Medicare and Medicare has determined the stay to be medically necessary.

Upon exhaustion of benefits under this Plan during this contract period, the Member must again qualify under Medicare and receive benefits from Medicare before the Plan's coverage will commence.

Skilled nursing facility stays must be reviewed by Blue Cross' Review Center and precertified as medically necessary after the first 100 days. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month before the first 100 days have ended. If the Review Center determines that the skilled nursing facility stay is not medically necessary, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage will not be guaranteed. If the Review Center declines to certify services as medically necessary but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the Plan.

If you have any questions concerning the Review Center's decisions regarding your treatment plan, call the Review Center's coordinator who managed your care at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your physician may appeal this decision by following the Utilization Review Appeal Procedure described on pages 38 through 40.

NOTE: Benefits are not payable for custodial care whether alone or in conjunction with other medically necessary services.

3. **The first three (3) pints of blood when disallowed by Medicare and unreplaced.**

4. **Mental health services and supplies as follows:**

   a. **Inpatient Services**

      Covered charges for services and supplies furnished by a hospital and a physician for treatment of mental or psychoneurotic disorders while confined in a hospital as a registered bed patient. Hospital charges for room and board in excess of the semi-private (two-bed) room rate and charges of a physician for psychiatric care in excess of a maximum payment of thirty-two dollars ($32.00) per day will be excluded.

   b. **Outpatient Services**

      The Plan will pay up to a maximum payment of thirty-two dollars ($32.00) for covered charges per day for psychiatric care as defined on page 50 for treatment of mental or psychoneurotic disorders while not confined in a hospital as a registered bed patient.

5. **Immunizations**:*

   Varicella Virus (chickenpox),
   Td booster (tetanus, diphtheria),
   Lyme Disease Vaccine covered to age 70,
   Hepatitis A.

   * Discuss your immunization needs with your physician.

6. **Lancets** and lancing devices for the self-administration of blood tests to monitor a covered condition (e.g., checking blood glucose level for self-management of diabetes).

7. **Services of a licensed physical or occupational therapist** for treatment of an acute condition upon referral by a physician.

8. **Services of a licensed speech therapist** limited to a lifetime maximum payment of five thousand dollars ($5,000) per Plan Member.

9. **Acupuncture or Acupressure Services** rendered by any provider qualified to perform acupuncture or acupressure for up to twenty (20) visits per calendar year.

10. **Services of a Christian Science nurse or practitioner,** including treatment in absentia.

11. **Hearing aid services as follows:**

    Hearing aid services include an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

The hearing aid (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to a maximum payment of two thousand dollars ($2,000) per Member once every twenty-four (24) months. The Plan provides payment of up to two thousand dollars ($2,000) regardless of the number of hearing aids purchased. This benefit also includes visits for fitting, counseling, adjustment, and repairs at no charge for a one-year period following the provision of a covered hearing aid.

The following are excluded under the Plan:

1. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
2. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.
3. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.
4. Replacement of a hearing aid more than once in any period of twenty-four (24) months.
5. Surgically implanted hearing devices.

Payment of Benefits Beyond Medicare

Covered charges applicable to Benefits Beyond Medicare will be payable as follows:

1. PERSCare will pay eighty percent (80%) of the first fifteen thousand dollars ($15,000) of covered charges incurred by a Plan Member during each calendar year. In other words, PERSCare will pay twelve thousand dollars ($12,000) and you will pay three thousand dollars ($3,000) for covered charges. However, the following out-of-pocket expenses will not be included in calculating the three thousand dollars ($3,000) you must pay:
   - expenses for vision care benefits.
   - expenses for outpatient prescription drugs.
   - expenses for mental health services and supplies.
2. PERSCare will pay one hundred percent (100%) for any additional amounts of covered charges, excluding charges for vision care, outpatient prescription drugs, and mental health services and supplies, incurred by that Plan Member during the same calendar year.
3. The lifetime maximum amount payable for speech therapy is five thousand dollars ($5,000) per Plan Member.

NOTE: Payments for all covered services are based on the Allowable Amount for such services, as defined on page 46, except for hospital providers. Covered charges with respect to hospital providers are the actual cost to the Plan Member for hospital services and supplies that are benefits of the Plan.

Temporary Absence Outside the United States

When covered charges are incurred during the first six (6) months of a temporary absence outside the United States and its territories (unless provided in Canada or Mexico*), PERSCare will provide the benefits as described in the PERSCare Basic Plan Evidence of Coverage booklet as though the Member incurring such charges were insured under that plan. If a Member is hospital-confined on the last day of the six (6) months' temporary absence outside the United States, benefits will be provided for the duration of the confinement or until the maximum benefits have been provided.

*Exception for Canadian and Mexican Hospitals. Medicare generally cannot pay for hospital or medical services outside the United States. But it can help pay for care in qualified Canadian or Mexican hospitals in three situations: (1) if you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the care you need; (2) if you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists; or (3) if you are in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs which requires that you be admitted to a Canadian hospital (this provision does not apply if you are vacationing in Canada).

When Medicare hospital insurance (Part A) covers your inpatient stay in a Canadian or Mexican hospital, your PERSCare medical insurance can cover necessary physician services and any required use of an ambulance.

Vision Care Benefits

PERSCare provides benefits for routine vision care services and supplies up to the maximum allowance shown below:

	Allowance
Complete eye examination	$35.00
Lens (each):	
Single vision	$20.00
Bifocal	$35.00
Trifocal	$45.00
Lenticular	$50.00
Contact lenses (see below)	$100.00
Frames	$30.00

Examinations are limited to one (1) per Plan Member and lenses are limited to two (2) per Plan Member during a calendar year. Frames are limited to one (1) set per Plan Member over a two-year period.

Once each calendar year, you may have an eye examination for refractive error, including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field, and muscle balance. If normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow-up visit for muscle balance will also be covered if medically necessary.

When an eye examination indicates that correction is necessary for proper visual health and welfare, PERSCare will pay up to the maximums stated for covered supplies.

Contact Lenses

When the Plan Member chooses contact lenses instead of other eyewear, PERSCare provides payment only up to the combined allowance for frames and lenses specified above, **but not to exceed one hundred dollars ($100.00)**.

PERSCare will also pay a maximum of one hundred dollars ($100.00) toward the purchase of contact lenses when medically necessary following cataract surgery, or if they are the only means by which vision in the better eye can be corrected to at least 20/70.

Vision Care Benefit Exclusions

The following are excluded under the Plan:

1. Lenses that do not require a prescription or sunglasses, plain or prescription. Glasses with a tint other than No. 1 or No. 2 will be considered sunglasses for the purpose of this exclusion.
2. Services and materials (a) in connection with non-surgical treatment or procedures, such as orthoptics and visual training; (b) received in a United States government hospital, furnished elsewhere by or for the United States government, or provided by any government plan or law under which the individual is or could be covered; or (c) provided under workers' compensation benefits.
3. Replacement of lenses or frames which were furnished under PERSCare and which have been lost, stolen or broken.
4. Any procedure done to correct a refractive error, including surgeries such as radial keratotomy, optical keratoplasty, or myoptic keratomileusis.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Program is administered by Caremark. This program will pay for prescription medications which are: (a) prescribed by a licensed physician in connection with a covered illness or accidental injury; (b) dispensed by a registered pharmacist, subject to the exclusions listed on pages 23 and 24; and (c) approved through the Coverage Management Programs described on pages 21 and 22. All prescription medications are subject to clinical review under coverage management programs described on pages 21 and 22 including utilization review.

Covered prescription drugs prescribed by a licensed physician and dispensed by a registered pharmacist may be obtained either through the Caremark Retail Pharmacy Program or the Caremark Mail Service Program.

The Plan's drug program is designed to save you and the Plan money without compromising safety and effectiveness standards by encouraging you to ask your physician to prescribe generic drugs whenever possible and to also prescribe medications on Caremark's Preferred Drug List. Members can still receive any covered medication and your physician still maintains the choice of medication prescribed.

Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

Copayment Structure

The Plan's copayment structure includes generic, Preferred and Non-Preferred Brand medications. The Member has an incentive to use generic and Preferred drugs, and mail service for maintenance medications. Your copayment will vary depending whether you use generic, Preferred or Non-Preferred brand-name medications, or whether you purchase maintenance medications at the retail pharmacy after the second fill.

The following table shows the copayment structure for the retail pharmacy and mail service programs:

Retail Pharmacy (Short-term use)		**Retail Pharmacy Maintenance Medications* filled at Retail Pharmacy after 2nd fill** (A maintenance medication* taken longer than 60 days for a long-term or chronic condition)		**Mail Service** (A maintenance medication* taken longer than 60 days for a long-term or chronic condition)	
Generic	**$5.00**	Generic	**$10.00**	Generic	**$10.00**
Preferred Brand	**$15.00**	Preferred Brand	**$25.00**	Preferred Brand	**$25.00**
Non-Preferred Brand	**$45.00**	Non-Preferred Brand	**$75.00**	Non-Preferred Brand	**$75.00**
Medically Necessary waiver of Non-Preferred Brand copayment**	**$30.00**	Medically Necessary waiver of Non-Preferred Brand copayment**	**$45.00**	Medically Necessary waiver of Non-Preferred Brand copayment**	**$45.00**
Up to a 34-day supply		**Up to a 34-day supply**		**Up to a 90-day supply**	
Out-of-Pocket Maximum, per person (Mail Service Only)		**not applicable**			**$1,000**

OUTPATIENT PRESCRIPTION DRUG PROGRAM

* A maintenance medication does not require frequent dosage adjustments, and is prescribed to treat a long-term condition, such as birth control, or chronic condition, such as arthritis, diabetes, and high blood pressure. Ask your physician if you will be taking a prescribed medication longer than 60 days. If you purchase a maintenance prescription at a retail pharmacy after the 2nd fill, you will be charged the applicable mail service copayment described above.

Examples of common long-term or chronic conditions:

Birth control
Hypertension or high blood pressure
Hyperlipidemic or High Cholesterol
Diabetes

Examples of common short-term acute illnesses or conditions:

Influenza
Pneumonia
Urinary tract infection

** In order to obtain a Non-Preferred Brand-Name Drug at the medically necessary Non-Preferred Brand copayment, you must request a waiver of the Non-Preferred Brand Copay based on medical necessity through Caremark's formal appeals process outlined on page 41. In order to establish medical necessity, your physician must document why you cannot tolerate the preferred products and the available generic alternatives, or that you have tried the preferred products or available generic alternatives without clinical success.

The copayment applies to each prescription order and to each refill. The copayment is not reimbursable and cannot be used to satisfy any deductible requirement. (Under some circumstances your prescription may cost less than the actual copayments, and you will be charged the lesser amount.)

All prescriptions filled by mail service will be filled with a FDA-approved bioequivalent generic substitute if one exists, unless your physician specifies otherwise. A one thousand-dollar ($1,000) maximum calendar year copayment (per person) applies to mail order prescriptions.

Although Generic Medications (defined on page 47) are not mandatory, the Plan encourages you to purchase generics whenever possible. Generic Medications may differ in color, size, or shape, but the Federal Drug Administration (FDA) requires that they have the same quality, strength, purity and stability as the Brand-Name Medications (defined on page 46). Prescriptions filled with Generic Medications have lower copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Retail Pharmacy Program

Medication for a short duration, up to a 34-day supply, may be obtained from a Participating Pharmacy by using your PERSCare ID card.

While this program was designed primarily for use in California, there are many Participating Pharmacies outside California that will also accept your PERSCare ID card. At Participating Pharmacies, simply show your ID card and pay either a five dollar ($5.00) copayment for generic medications, a fifteen dollar ($15.00) copayment for Preferred brand-name medications, a forty-five dollar ($45.00) copayment for Non-Preferred brand-name medications, or a thirty ($30.00) copayment for Medically Necessary Waiver of Non-Preferred Brand copayment. If the pharmacy does not accept your ID card, and is a Non-Participating Pharmacy (defined on page 48), there is additional cost to you.

To find a Participating Pharmacy close to you, simply visit the Caremark Web site at www.caremark.com, or contact Caremark Customer Service at 1-866-999-7377. If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described on page 18.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

1. Take your prescription to any Participating Pharmacy. To locate a Participating Pharmacy near you, visit the Caremark Web site at www.caremark.com or contact Caremark Customer Service at 1-866-999-7377.

2. Present your PERSCare ID card to the pharmacist. The pharmacist will fill the prescription for up to a thirty-four (34) day supply of medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.

3. You will be required to pay the pharmacist your appropriate copayment for each prescription order or refill. You may be required to sign a receipt for your prescription at the pharmacy.

4. In the event you do not have your ID card prior to going to the pharmacy, contact Caremark Customer Service at 1-866-999-7377 for assistance with processing your prescription at a Participating Pharmacy. In order to obtain an ID card, you may contact the Blue Cross Customer Service Department at 1-877-737-7776. If you pay the Participating Pharmacy the full cost of your medication at the time of purchase without presenting your ID card, your reimbursement will be the same as if you had used a Non-Participating Pharmacy. (See example below.)

Non-Participating Pharmacy

If you purchase medications at a Non-Participating Pharmacy, either inside or outside California, **you will be required to pay the full cost of the medication at the time of purchase.** To receive reimbursement, complete a Caremark Prescription Drug Claim Form and mail it to the address indicated on the form. **Claims must be submitted within twelve (12) months from the date of purchase to be covered. Any claim submitted outside the twelve (12) month time period will be denied.**

Payment will be made directly to you. It will be based on the amount that the Plan would reimburse a Participating Pharmacy minus the applicable copayment.

Example of Direct Reimbursement Claim for a Preferred Brand-Name Medication

1.	Pharmacy charge to you (Retail Charge)	$ 38.00
2.	Minus Caremark's Allowable Amount on a Preferred Brand-Name Medication	($ 20.00)
3.	Amount you pay in excess of Caremark's Allowable Amount due to not using your ID Card	$ 18.00
4.	Plus your copayment for a Preferred Brand-Name Medication	$ 15.00
5.	Your out-of-pocket cost would be	$ 33.00

If you had used your ID Card, the Pharmacy would only charge the Plan $20.00 for the drug, and your out-of-pocket cost would only have been the $15.00 copayment.

As you can see, using Non-Participating Pharmacies, or not using your ID card at a Participating Pharmacy, results in substantially more cost to you than using your ID card at a Participating Pharmacy. Under certain circumstances, your copayment amount may be higher than the cost of the medication and no reimbursement would be allowed.

Note: Covered medications purchased from your physician will be reimbursed under the Non-Participating Pharmacy benefit through Caremark.

Direct Reimbursement Claim Forms

To obtain a Caremark Prescription Drug Claim Form and information on Participating Pharmacies, visit the Caremark Web site at www.caremark.com, or contact Caremark Customer Service at 1-866-999-7377.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Mail Service Program

Maintenance medication for long-term or chronic conditions may be obtained by mail, for up to a ninety (90) day supply, through Caremark's Mail Service Program. Mail service offers additional savings and convenience if you need prescription medication on an ongoing basis. For example:

- **Additional Savings:** You can receive up to a **ninety (90) day supply** of medication for only ten dollars ($10.00) for each generic medication, twenty-five dollars ($25.00) for each Preferred brand-name medication, seventy-five dollars ($75.00) for each Non-Preferred brand-name medication, or forty-five dollars ($45.00) for each Medically Necessary Waiver of Non-Preferred Brand copayment. In addition to out-of-pocket cost savings, you save additional trips to the pharmacy.
- **Convenience:** Your medication is delivered to your home by mail.
- **Security:** You can receive up to a 90-day supply of medication at one time.
- **A toll-free customer service number:** Your questions can be answered by contacting a Caremark Customer Service Representative at 1-866-999-7377.
- **Out-of-pocket maximum:** Your maximum calendar year copayment (per person) through the mail service program is one thousand dollars ($1,000).

How To Use The Mail Service Program

If you must take medication on an ongoing basis, the Mail Service Program is ideal for you. To use this program, just follow these steps:

1. Ask your physician to prescribe maintenance medications for up to a ninety (90) day supply, plus refills if appropriate.

2. Send the following to Caremark Mail Service Program in the pre-addressed mail service envelope:

   a. The original prescription order(s) – **Photocopies are not accepted**.

   b. A completed Caremark Participant Profile/Order Form. The Caremark Participant Profile/Order Form can be obtained by visiting the Caremark Web site at www.caremark.com or by contacting Caremark Customer Service at 1-866-999-7377 and using the automated phone system or requesting to speak with a customer service representative.

   c. A check or money order for an amount that covers your copayment for each prescription: $10 generic, $25 Preferred brand-name, $75 Non-Preferred brand-name, or $45 Medically Necessary Waiver of Non-Preferred Brand copayment. Checks or money orders should be made payable to Caremark. You can also have your copayment(s) charged to your credit card (VISA, Discover, MasterCard, or American Express) by providing the information on the Participant Profile/Order Form.

3. To order your mail service refill:

   a. Use Caremark's Web site
   Visit **www.caremark.com**, your on-line prescription service, to order prescription refills or inquire about the status of your order. You will need to register on the site and log in. When you register you will need the cardholder's ID number and Group Code that is indicated on the ID card.

   b. Call Caremark's Automated Refill Phone System
   Caremark's automated telephone service gives you a convenient way to refill your prescriptions at any time of the day or night. Call 1-866-999-7377 for Caremark's fully automated refill phone service. When you call, be ready to provide the cardholder's ID number, member's year of birth, and your credit card number along with the expiration date.

c. Refill by Mail

Order three weeks in advance of your current prescription running out. Refill dates will be included on the prescription label you receive from Caremark. Attach the refill label provided with your prescription order to a Caremark Mail Service Order Form along with your payment. Mail the order form to Caremark in the pre-addressed envelope included with your previous shipment.

If you have questions regarding Caremark's Mail Service Program or to find out if your medication is on Caremark's Preferred Drug List, visit the Caremark Web site at **www.caremark.com** or contact Caremark Customer Service at 1-866-999-7377. All prescriptions received through mail service will be filled with a FDA-approved bioequivalent generic substitute if one exists, unless your physician specifies otherwise.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include a Prior Authorization Program, Point of Sale Utilization Review, Pharmaceutical Therapy Management, and Specialty Pharmacy Services. Additional programs may be added at the discretion of the Plan.

The Plan may implement additional new programs designed to ensure the medical appropriateness and cost effectiveness of prescription medications dispensed to its Members under this Plan. **As new drugs are developed, including generic versions of brand-name drugs, or when drugs receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those drugs or class of drugs under the Plan. The Plan reserves the right to exclude, discontinue or limit coverage of those drugs or class of drugs following such review. Any benefit payments made for a prescription medication shall not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that medication at a later date.**

Prior Authorization Program

The purpose of the Prior Authorization Program, which is administered by Caremark in accordance with the Plan, is to ensure that certain medications, including but not limited to those listed below, are used in accordance with specific criteria for medical appropriateness and cost-effectiveness.

The drugs and drug categories listed below as requiring Prior Authorization are subject to change. If you fail to obtain Prior Authorization, or if Prior Authorization is denied, the Plan will not cover the cost of the medication.

If your prescription requires a Prior Authorization, the dispensing pharmacist is notified by an automated message. Your physician is then contacted by a Caremark pharmacist to verify that the prescribed medication meets the Plan's approved guidelines. This process is usually completed within forty-eight (48) hours. You will receive notification from Caremark if Prior Authorization is denied.

The following drug categories may be subject to Prior Authorization:

Acne Therapy Retin-A (Over the age of 33)
Amphetamines (Adderall, Desoxyn)
Fertility Drugs (Clomid) Note: These drugs are covered for indications other than infertility.

Point of Sale Utilization Review

The following drug categories are subject to review through Caremark's automated "Point of Sale" utilization review program. The dispensing pharmacist may receive a message that "Plan Limits Exceeded" or "Prior Authorization Required" depending on the drug category. Drug categories with an (*) are subject to a quantity limitation that may differ from the 34-day supply.

COX-2 Inhibitor Therapy (Celebrex, Vioxx)
Erectile Dysfunction Therapy*
Onychomychosis (Lamisil, Sporanox)
Paget's Disease Management* (Actonel, Skelid)
Pain Management (Stadol NS)
Vaginitis Management* (Diflucan 150mg.)
Anti-Influenza Therapy (Tamiflu, Relenza)
NSAID Therapy (Toradol)

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Pharmaceutical Therapy Management

In certain situations, Caremark's clinical staff collaborates with your physician(s) by providing consultative review and advice so that medications are used in the most medically appropriate and cost-effective manner. This consultation is provided to ensure that appropriate and safe medication prescribing practices are being followed and that medications are prescribed in accordance with FDA approved manufacturer labeling, nationally accepted treatment guidelines, and medical practice standards. This consultation could result in a change in the drug prescribed, the dosage prescribed, or the duration of therapy. Your prescription will not be changed unless your prescribing physician or your prescribing physician's agent determines that a change is medically appropriate.

In addition, Caremark will collaborate with your physician to encourage the most cost effective and clinically appropriate medications by considering the following step-therapy management:

1. Over-the-counter (OTC) brand medications
2. Prescription strength generic equivalents
3. Preferred brand-name drugs, when appropriate

If your physician prescribes an OTC medication, you will not require a prescription. However, the cost of the medication will be at your expense as these medications are not covered by the Plan.

If a change is made to your prescription drug therapy, you will receive notice of such change with your prescription order. If you have any questions regarding a change to your pharmaceutical therapy, contact your prescribing physician or Caremark's Member Services at 1-866-999-7377.

Specialty Pharmacy Services

Caremark's Specialty Pharmacy Services Program offers convenient access and delivery of specialty injectable medications as well as personalized service and educational support. A Caremark Pharmacy Services specialist will be your primary contact for ongoing delivery needs, questions, and support.

To obtain injectable medications for the following therapies, you or your physician should call 1-800-237-2767. Caremark's Specialty Pharmacy Services offers 24-hour access to information, personal service and clinical consultation.

Asthma (Xolair)
Bleeding Disorders (Hemophil M, Helixate)
Blood Modifying Agents (Epogen, Procrit)
Cancer Treatment/Chemotherapeutic agents (Gleevec)
Enzyme Deficiency (Ceredase, Cerezyme)
Growth Hormones (Genotropin, Nutropin, Protropin)
Hepatitis C (Peg-Intron, Rebetol)
Immune Deficiency (Gammagard, Gamimmune)
Multiple Sclerosis (Betaseron, Copaxone, Rebif)
Myeloid Stimulants (Leukine, Neupogen)
Psoriasis (Reptiva)
Pulmonary Hypertension (Tracleer)
Respiratory Agents (Pulmozyme)
Rheumatoid Arthritis (Enbrel)
Transplant Therapies (Simulect, Zenapax)

The above drug therapies are subject to change, and the drugs listed are examples only. Please contact Caremark Specialty Pharmacy Services at 1-800-237-2767 for specific coverage information.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Drugs or medicines obtainable without a physician's prescription, often called over-the-counter (OTC) drugs, except insulin and glucose test strips.

2. Contraceptives in the form of condoms, jellies, ointments, foams, or devices (except diaphragms). Intra-uterine devices (IUDs) and time-released subdermal drugs (e.g., Norplant implants) are excluded.

3. Dietary and herbal supplements, minerals, health aids, and any vitamins whether available over the counter or by prescription, except prescriptions for vitamin D.

4. Anorexiants and appetite suppressants or any other anti-obesity drugs.

5. Anti-dandruff preparations.

6. Laxatives, except as prescribed for diagnostic testing.

7. Supplemental fluorides.

8. Charges for the purchase of blood or blood plasma.

9. Hypodermic needles and syringes, except as required for the administration of a covered drug.

10. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use. *

11. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.

12. Drugs designed solely for or used to deter smoking.

13. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any drug or medication prescribed for experimental indications.

14. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.

15. Any drug or medication which is not **legally** available for sale within the continental United States. Medications obtained outside of the United States, unless such medications would be covered under this section if obtained within the United States.

16. Any charges for injectable immunization agents, desensitization products or allergy serum, or biological sera, including the administration thereof. *

17. Professional charges for the administration of prescription drugs or injectable insulin. *

18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility. *

19. Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *

20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or medication furnished by any other drug or medical services for which no charge is made to the Plan Member.

21. Any quantity of dispensed medications which exceeds a 34-day supply, unless prescribed for chronic conditions and obtained through the Mail Service Prescription Drug Program. Mail service prescriptions are limited to a ninety (90) day supply of covered medications as prescribed by a physician.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

22. Refills of any prescription in excess of the number of refills specified by a physician.

23. Any medication dispensed more than one (1) year following the date of the physician's prescription order.

24. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the mail service pharmacy.

25. Any quantity of dispensed medications that is deemed inappropriate as determined through Caremark's coverage management programs.

Services Covered By Other Benefits

When the expense incurred for a service or supply is covered under another benefit section of the Plan, it is not a Covered Expense under the Outpatient Prescription Drug Program benefit.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

This Plan supplements your Medicare benefits and provides benefits beyond Medicare. Benefits provided by this Plan beyond those covered by Medicare are subject to review for medical necessity before, during and/or after services have been rendered.

The following exclusions apply only to those services not covered by Medicare. The title of each exclusion is not intended to be fully descriptive of the exclusion; rather, it is provided solely to assist the Plan Member to easily locate particular items of interest or concern. Remember that a particular condition may be affected by more than one exclusion.

Under no circumstances will this Plan be liable for payment of costs incurred by a Plan Member or dependent for treatment deemed by CalPERS or its Plan administrators to be experimental or investigational or otherwise not eligible for coverage.

General Exclusions

Benefits of this Plan are not provided for, or in connection with,[*] the following:

1. **Aids and Environmental Enhancements.**

   a. The rental or purchase of aids, including, but not limited to, ramps, elevators, stair lifts, swimming pools, spas, hot tubs, air filtering systems or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

   b. Any modification made to dwellings, property or motor vehicles, whether or not their use or installation is for purposes of providing therapy or easy access.

2. **Benefit Substitution/Flex Benefit/In Lieu Of.** Any program, treatment, service, or benefit cannot be substituted for another benefit or non-existing benefit. For example, a member may not receive home health care benefits in lieu of an admission to a skilled nursing facility.

3. **Chemical Dependency.** Charges incurred for treatment relating to chemical dependency, including nicotine addiction.

4. **Chiropractic X-rays.** X-rays taken in a chiropractor's office are not covered; however, if X-rays are taken at a Medicare-approved facility, they will be covered.

5. **Close-Relative Services.** Charges for services performed by a close relative or by a person who ordinarily resides in the Plan Member's home.

6. **Convenience Items and Non-Standard Services and Supplies.** Services and supplies determined by the Plan as not medically necessary or generally furnished for the diagnosis or treatment of the particular illness, disease or injury; or services and supplies that are furnished primarily for the convenience of the Plan Member, irrespective of whether or not prescribed by a physician.

7. **Custodial Care.**

   a. Custodial care provided either in the home or in a facility, unless provided under the Hospice Care benefit.

   b. Services provided by a rest home, a home for the aged, a custodial nursing home, or any similar facility.

8. **Dental Implants.** Dental implants and any related services.

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[*] The phrase "in connection with" means any medical condition associated with an excluded medical condition (i.e., an integral part of the excluded medical condition or derived from it).

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

9. **Equipment and Supplies.** Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, dehumidifiers, exercise equipment or any other equipment not primarily medical in nature; and supplies for comfort, hygiene or beautification, including wigs.

10. **Excess Charges.** Any expense incurred for services of a physician or other health care provider in excess of Plan benefits.

11. **Experimental or Investigational Practices or Procedures.** Experimental or investigational practices or procedures, and services in connection with such practices or procedures, as defined on page 47.

12. **Government-Provided Services.** Any services provided by a local, state or federal government agency, unless reimbursement by this Plan for such services is required by state or federal law.

13. **Home Infusion Therapy.** The cost and administration of medications or fluids by the intravenous route in the home setting. (Note: Infusion therapy is a benefit that is available in other settings that are approved by Medicare, such as outpatient infusion centers and skilled nursing facilities.)

14. **Marriage and Family Counseling.** Counseling by any physician for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children which are not derived from a primary psychiatric or psychological diagnosis or condition.

15. **Non-Listed Benefits.** Services not specifically listed as benefits or not reasonably medically linked to or connected with listed benefits, whether or not prescribed by a physician or approved by Medicare.

16. **Personal Development Programs.** For or incident to vocational, educational, recreational, art, dance, music, reading therapy, or exercise programs (formal or informal).

17. **Psychiatric or Psychological Care.**

    a. Treatment of the following conditions is excluded under this Plan:

        1. personality disorders;
        2. sexual deviations and disorders;
        3. abuse of drugs;
        4. conduct disorders;
        5. mental retardation and developmental delays;
        6. conditions of abnormal behavior which are not directly attributable to a mental disorder which is the focus of attention or treatment;
        7. attention deficit disorders.

    b. Telephone consultations.

    c. Psychological testing or testing for intelligence or learning disabilities unless medically necessary to assess brain function suspected to be impaired due to trauma or organic dysfunction.

    d. Services on court order or as a condition of parole or probation unless the services are determined to be medically necessary and appropriate for the condition being treated and otherwise covered by the Plan.

    e. Marriage and family counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children.

    NOTE: Any dispute regarding a psychiatric condition will be resolved with reference to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Fourth Edition. Washington, DC, American Psychiatric Association, 1994. Use of DSM-IV to resolve disputes is subject to change as new editions are published.

18. **Rehabilitation or Rehabilitative Care.**

    a. Outpatient charges in connection with conditioning exercise programs (formal or informal).
    b. Any testing, training or rehabilitation for educational, developmental or vocational purposes.

19. **Telephone, Facsimile Machine, and E-mail Consultations.** Telephone, facsimile machine, and e-mail consultations for any purpose, whether between the physician or other provider and the subscriber or subscriber's family, or involving only physicians or other providers.

20. **Totally Disabling Conditions.** Services or supplies for the treatment of a total disability, if benefits are provided under the extension of benefits provisions of (a) any group or blanket disability insurance policy, or (b) any health care service plan contract, or (c) any hospital service plan contract, or (d) any self-insured welfare benefit plan.

21. **Voluntary Payment of Non-Obligated Charges.** Services for which the Plan Member is not legally obligated to pay, or services for which no charge is made to the Plan Member in the absence of health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

    a. It must be internationally known as being devoted mainly to medical research, and
    b. At least ten percent (10%) of its yearly budget must be spent on research not directly related to patient care, and
    c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and
    d. It must accept patients who are unable to pay, and
    e. Two-thirds of its patients must have conditions directly related to the hospital's research.

22. **War.** Conditions caused by war, whether declared or undeclared.

23. **Workers' Compensation, Services Covered By.** Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of the injury or disease.

Medical Necessity Exclusion

The fact that a physician or other provider may prescribe, order, recommend, or approve a service, supply or hospitalization does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion or limitation. The Plan reserves the right to review all claims to determine if a service, supply, or hospitalization is medically necessary. The Plan may limit the benefits for those services, supplies or hospitalizations that are not medically necessary.

Limitations Due to Major Disaster or Epidemic

In the event of any major disaster or epidemic, Physician Members shall render or attempt to arrange for the provision of covered services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available; but neither the Plan, Blue Cross nor Physician Members have any liability or obligation for delay or failure to provide any such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

CONTINUATION OF COVERAGE

Continuation of Group Coverage

Eligibility for Continuation of Group Coverage under PERSCare is dependant upon your employer's participation in the CalPERS Health Benefits Program. If an employer terminates participation in the CalPERS Health Benefits Program, employees currently enrolled in COBRA or CalCOBRA will have the option to convert to an individual plan (see Individual Conversion Plan on page 30) or may choose to continue coverage under COBRA or CalCOBRA with the group health plan providing health care coverage to the employer. A participant in COBRA or CalCOBRA may not continue coverage under PERSCare if the employer ceases to participate in the CalPERS Health Benefits Program.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of group coverage is provided through federal legislation and allows an enrolled active or retired employee or his or her enrolled family members, other than a domestic partner or a child of a domestic partner, who lose their regular group coverage because of certain qualifying events to elect continuation of coverage for eighteen (18) or thirty-six (36) months.

An eligible active or retired employee or his or her family member(s) is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the required premium is paid. The benefits of the continuation of coverage are identical to the group Plan and the cost of coverage may not exceed one hundred and two percent (102%) of the applicable group premium rate, except for the employee who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits, in which case, the cost of coverage for months nineteen (19) through twenty-nine (29) shall not exceed one hundred and fifty percent (150%) of the applicable group premium rate. No employer contribution is available to cover the premium.

Qualifying Events

Two qualifying events allow employees to request the continuation of coverage for eighteen (18) months: (This coverage may be continued for up to twenty-nine (29) months for federally recognized disabled employees.)

1. the covered employee's separation from employment (other than by reason of gross misconduct);

2. reduction in the covered employee's hours to less than half-time (or a permanent intermittent employee not working the required hours during a control period).

The following qualifying events allow enrolled family member(s) to elect the continuation of coverage for up to thirty-six (36) months:

1. the employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS);

2. the divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse;

3. a dependent child ceases to be a dependent child due to marriage or attainment of age twenty-three (23).

Effective Date of the Continuation of Coverage

If elected, COBRA continuation of coverage is effective on the date coverage under the group Plan terminates.

Termination of Continuation of Group Coverage

The continuation of coverage will remain in effect for the specified period of time, or until any one of the following events terminates the coverage:

1. termination of all employer-provided group health plans; or
2. the enrollee fails to pay the required premiums on a timely basis; or

3. the enrollee first becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation after electing COBRA; or
4. the continuation of coverage was extended to twenty-nine (29) months and there has been a final determination that the enrollee is no longer disabled; or
5. the Plan Member is terminated from the Plan for cause.

Notification of a Qualifying Event

You will receive notice from your employer of your eligibility for COBRA continuation of coverage if your employment is terminated or your number of work hours is reduced.

The employee, retiree, or affected family member is responsible for requesting information about COBRA continuation of coverage in the event of divorce, legal separation or a dependent child's loss of eligibility.

Contact your employing agency or CalPERS directly if you need more information about your eligibility for COBRA continuation of coverage.

CalCOBRA Continuation of Group Coverage

Certain former employees and their enrolled family members who begin receiving continuation coverage under federal COBRA on or after January 1, 2003, and exhaust their continuation coverage under federal COBRA provisions may be eligible to further continue coverage for medical benefits only under the California COBRA Program (CalCOBRA).

Qualifying Events

Employees and their family members can elect to continue coverage for up to the balance of thirty-six (36) months (COBRA and CalCOBRA combined) if their federal COBRA continuation ends following:

1. 18 months after the employee's separation from employment or reduction in work hours; or
2. 29 months after the employee's separation from employment or reduction in work hours, if the continuation was extended because of entitlement to Social Security disability benefits.

Notification Requirements

You will receive notice of your right to further elect coverage under CalCOBRA from Blue Cross within 180 days prior to the date federal COBRA ends. To elect CalCOBRA coverage, you must notify Blue Cross in writing within 60 days of the date your coverage under federal COBRA ends or the date of notification of eligibility, if later.

Effective Date of CalCOBRA Continuation of Coverage

If elected, this continuation will begin after the federal COBRA coverage ends and will be administered under the same terms and conditions as if COBRA had remained in force.

Premiums

Premiums for this continuation coverage may not exceed:

1. one hundred and ten percent (110%) of the applicable group premium rate if coverage under federal COBRA ended after 18 months; or
2. one hundred and fifty percent (150%) of the applicable group premium rate if coverage under federal COBRA ended after 29 months.

The first payment is due along with the enrollment form within 45 days after electing CalCOBRA continuation coverage. This payment must be sent to Blue Cross at P.O. Box 629, Woodland Hills, CA 91365-0629 by certified mail or other reliable means of delivery, in an amount sufficient to pay any required premiums and premiums due. Failure to submit the correct amount within this 45-day period will disqualify the former employee or family member from receiving continuation coverage under CalCOBRA. Succeeding premiums are due on the first day of each following month.

The amounts of premiums may be changed by Blue Cross as of any premiums due date. Blue Cross will provide enrollees with written notice at least 30 days prior to the date any increase in premiums goes into effect.

Termination of CalCOBRA Continuation of Coverage

This CalCOBRA continuation of coverage will remain in effect for the specified period of time, or until any one of the following events automatically terminates the coverage:

1. the employer ceases to maintain any group health plan; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee becomes covered under any other health plan that does not include an exclusion or limitation relating to a pre-existing condition that the enrollee has; or
4. the enrollee becomes entitled to Medicare; or
5. the enrollee becomes covered under a federal COBRA continuation; or
6. the enrollee moves out of Blue Cross' service area; or
7. the enrollee commits fraud.

A Plan Member whose continuation of group coverage is terminated or expires under the group continuation plan may be eligible to enroll in an individual conversion plan (see page 30).

Individual Conversion Plan

Regardless of age, physical condition or employment status, you and your enrolled dependents may transfer to an individual conversion plan then being issued by Blue Cross when enrollment is terminated, other than by voluntary cancellation or failure to continue enrollment or to make contributions while in a non-pay status. The individual conversion plan will also be available to a Plan Member whose continuation of group coverage expires under the group continuation plan.

However, if this Plan is replaced by your employer with another Plan, transfer to the Blue Cross conversion plan will not be permitted.

Applications for the conversion plan must be received by Blue Cross within sixty-three (63) days from the date coverage under PERSCare is terminated.

To request an application, write to:

Blue Cross of California
P.O. Box 9153
Oxnard, CA 93031-9153

Benefits and rates of individual conversion plans will be different from those provided under PERSCare, and the premiums will usually be greater than PERSCare's.

An individual conversion plan is also available to:

- Family members in the event of the employee's death;
- Children upon marrying or attaining age twenty-three (23) while enrolled under PERSCare;
- Family members of a subscriber who enters military service;
- The spouse of a Plan Member whose marriage has terminated
- The domestic partner of a subscriber whose domestic partnership has been terminated.

When a child reaches age twenty-three (23), or if a family member becomes ineligible for any other reason given above, it is your responsibility to inform Blue Cross. Upon receiving notification, Blue Cross will offer such family member an individual conversion plan.

CONTINUATION OF COVERAGE

Benefits After Termination

1. In the event the Plan is terminated by the CalPERS Board of Administration or by PERSCare, PERSCare shall provide an extension of benefits for a Plan Member who is totally disabled at the time of such termination, subject to the following provisions:

   a. For the purpose of this benefit, a Plan Member is considered totally disabled (1) when confined in a hospital or skilled nursing facility or confined pursuant to an alternative care arrangement; (2) when, as a result of accidental injury or disease, prevented from engaging in any occupation for compensation or profit or prevented from performing substantially all regular and customary activities usual for a person of the Plan Member's age and family status; or (3) when diagnosed as totally disabled by the Plan Member's physician and such diagnosis is accepted by PERSCare.

   b. The services and benefits under this Plan shall be furnished solely in connection with the condition causing such total disability and for no other condition not reasonably related to the condition causing the total disability, illness or injury. Services and benefits of this Plan shall be provided only when written certification of the total disability and the cause thereof has been furnished to Blue Cross by the Plan Member's physician within thirty (30) days from the date the coverage is terminated. Proof of continuation of the total disability must be furnished by the Plan Member's physician not less frequently than at sixty (60) day intervals during the period that the termination services and benefits are available.

   Extension of coverage shall be provided for the shortest of the following periods:

   - Until the total disability ceases;
   - For a maximum period of twelve (12) months after the date of termination, subject to PERSCare maximums; or
   - Until the Plan Member's enrollment under any replacement hospital or medical plan without limitation to the disabling condition.

2. If on the date a Plan Member's coverage terminates for reasons other than termination of the Plan by the CalPERS Board, by PERSCare, or by voluntary cancellation, and the date of such termination of coverage occurs during the Plan Member's certified confinement in a hospital or skilled nursing facility or alternative care arrangement, the services and benefits of this Plan shall be furnished solely in connection with the conditions causing such confinement. Extension of coverage shall be provided for the shortest of the following periods:

   - For a maximum period of ninety-one (91) days after such termination; or
   - Until the Plan Member can be discharged from the hospital or skilled nursing facility as determined by PERSCare; or
   - Until the Plan's maximum benefits are paid.

LIABILITIES

Third-Party Liability

If a Plan Member receives medical services covered by PERSCare for injuries caused by the act or omission of another person (a "third party"), the Plan Member agrees to:

1. promptly assign his or her rights to reimbursement from any source for the costs of such covered services; and
2. reimburse PERSCare, to the extent of benefits provided, immediately upon collection of damages by him or her for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and
3. provide PERSCare with a lien, to the extent of benefits provided by PERSCare, upon the Plan Member's claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and
4. the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for the Member's illness or injury; and
5. notify Blue Cross of any claims filed against a third party for recovery of the cost of medical services obtained for injuries caused by the third party; and
6. cooperate with CalPERS and Blue Cross in protecting the lien rights of PERSCare against any recovery from the third party; and
7. obtain written consent from CalPERS prior to settling any claim with the third party that would release the third party from the lien or limit the rights of PERSCare to recovery.

Pursuant to Government Code section 22947, a PERSCare member (or his/her attorney) must immediately notify the Plan, via certified mail, of the existence of any claim or action against a third party for injuries allegedly caused by the third party. Notices of third party claims and actions must be sent to:

PERSCare Health Plan
Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

PERSCare has the right to assert a lien for costs of health benefits paid on behalf of a plan member against any settlement with, or arbitration award or judgment against, a third party. PERSCare will be entitled to collect on its lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

Plan Member Liability When Payment is Made by PERSCare

When covered services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERSCare, the Plan Member is responsible only for any applicable deductible and/or copayment. However, if covered services are provided by a non-Preferred Provider or non-Participating Pharmacy, the Plan Member is responsible for any amount PERSCare does not pay.

When a benefit specifies a maximum payment and the Plan's maximum has been paid, the Plan Member is responsible for any charges above the benefit maximum, regardless of the provider's status who renders the services.

In the Event of Insolvency of PERSCare

If PERSCare should become insolvent and no payment, or partial payment, is made for covered services, the Plan Member is responsible for any charges incurred, regardless of the provider's status who renders the services. Providers may bill the Member directly and the Member will have no recourse against the California Public Employees' Retirement System, its officers, or employees for reimbursement of his or her expenses.

LIABILITIES

Plan Liability for Provider Services

In no instance shall the Plan or Blue Cross be liable for negligence, wrongful acts or omissions of any person, physician, hospital, or hospital employee providing services.

Maintenance of Preferred Provider Reimbursement Levels

If a Preferred Provider breaches or terminates its contract with Blue Cross of California for Preferred Provider services, PERSCare may, based upon medical necessity, approve continuation of care at the Preferred Provider level of reimbursement. Upon PERSCare's approval, reimbursement shall be made at the Preferred Provider level of reimbursement and the balance will be the obligation of the Plan Member.

In the event that a Preferred Provider is unwilling or unable to provide continuing care to a Plan Member, then it shall be the responsibility of the Plan Member to choose an alternative provider and to determine the Preferred Provider status of that provider.

COORDINATION OF BENEFITS

(Not Applicable to the Drug Program)

Coordination of Benefits provides maximum coverage for medical and hospital bills at the lowest cost by avoiding excessive payments. A Plan Member who is covered under more than one group plan will not be permitted to make a "profit" by collecting benefits on any claim in excess of the billed amount. Benefits will be coordinated between the plans to provide appropriate payment, not to exceed 100% of the Allowable Amount.

This Coordination of Benefits section will apply only to Benefits Beyond Medicare and Vision Care Benefits.

Blue Cross will send you a questionnaire annually regarding other health care coverage or Medicare coverage. ***You must provide this information to Blue Cross within 30 calendar days.*** If you do not respond to the questionnaire, claims will be denied or delayed until Blue Cross receives the information. You may provide the information to Blue Cross in writing or by telephoning Customer Service.

(The meanings of key terms used in these Coordination of Benefits provisions are shown below under Definitions.)

Effect on Benefits

If this Plan is determined to be the primary carrier, this Plan will provide its benefits in accordance with the plan design and without reductions due to payments anticipated by a secondary carrier. Physician Members and other Preferred Providers may request payment from the secondary carrier for any difference between their Billed Charges and this Plan's payment.

If the other carrier has the primary responsibility for claims payment, your claim submission under this Plan must include a copy of the primary carrier's Explanation of Benefits together with the itemized bill from the provider of service. Your claim cannot be processed without this information. HMO plans often provide benefits in the form of health care services within specific provider networks and may not issue an Explanation of Benefits for covered services. If the primary carrier does not provide an Explanation of Benefits, you must submit that plan's official written statement of the reason for denial with your claim.

When this Plan is the secondary carrier, its benefits may be reduced so the combined benefit payments and services of all the plans do not exceed 100% of the Allowable Amount. The benefit payment by this Plan will never be more than the sum of the benefits that would have been paid if you were covered under this Plan only.

If this Plan is a secondary carrier with respect to a Plan Member and Blue Cross is notified that there is a dispute as to which plan is primary, or that the primary carrier has not paid within a reasonable period of time, this Plan will provide the benefits that would have been paid if it were the primary carrier, **only** when the Plan Member:

1. Assigns to this Plan the right to receive benefits from the other plan to the extent that this Plan would have been obligated to pay as secondary carrier, **and**

2. Agrees to cooperate fully in obtaining payment of benefits from the other plan, **and**

3. Allows Blue Cross to obtain confirmation from the other plan that the benefits claimed have not previously been paid.

Order of Benefits Determination

When the other plan does not have a Coordination of Benefits provision, it will always be the primary carrier. Otherwise, the following rules determine the order of benefit payments:

1. A plan which covers the Plan Member as other than a dependent shall be the primary carrier.

2. When a plan covers a dependent child whose parents are not separated or divorced, and each parent has a group plan which covers the dependent child, the plan of the parent whose birthdate (excluding year of birth) occurs earlier in the calendar year shall be primary carrier. If either plan does not have the birthday rule provision of this paragraph regarding dependent children, primary carrier shall be determined by the plan that does not include this provision.

3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order:

    a. the plan of the parent with custody of the child;

    b. if the custodial parent has remarried, the plan of the stepparent married to the parent with custody of the child;

    c. the plan of the noncustodial parent without custody of the child;

    d. if the noncustodial parent has remarried, the plan of the stepparent married to the parent without custody of the child.

4. Regardless of paragraph 3 above, if there is a court decree that otherwise establishes a parent's financial responsibility for the medical, dental, or other health-care expenses of the child, then the plan which covers the child as a dependent of that parent shall be the primary carrier.

5. If the above rules do not apply, the plan which has covered the Plan Member for the longer period of time shall be the primary carrier, except for:

    a. A plan covering a Plan Member as a laid-off or retired employee or the dependent of a laid-off or retired employee will determine its benefits after any other plan covering that person as other than a laid-off or retired employee or their dependent (This does not apply if either plan does not have a provision regarding laid-off or retired employees.); or

    b. Two plans that have the same effective date will split Allowable Expense equally between the two plans.

Definitions

Allowable Expense — A charge for services or supplies which is considered covered in whole or in part under at least one of the plans covering the Plan Member.

Explanation of Benefits — The statement sent to an insured by their health insurance company listing services provided, amount billed, eligible expenses and payment made by the health insurance company. HMO plans often provide health care services for members within specific provider networks and may not provide an Explanation of Benefits for covered services.

Other Plan — Any blanket or franchise insurance coverage, group service plan contracts, group practice or any other prepayment coverage on a group basis, any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans, or Medicare.

Primary Carrier — A plan which has primary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and will have its benefits determined first without regard to the possibility that another plan may cover some expenses.

Secondary Carrier — A plan which has secondary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and may reduce its benefit payments after the primary carrier's benefits are determined first.

MEDICAL CLAIMS APPEAL PROCEDURE

The procedures outlined below are designed to ensure the Plan Member full and fair consideration of complaints submitted to the Plan. The procedures should be followed carefully and in the order listed.

Claims for payment must be submitted to Blue Cross within ninety (90) days after the date of the medical service, if reasonably possible, but in no event, except for the absence of legal capacity, may claims be submitted later than fifteen (15) months from the date of service or payment will be denied.

The following procedures shall be used to resolve any dispute which results from any act, error, or omission with respect to any **medical claim** filed by or on behalf of a Plan Member. (See Utilization Review Appeal Procedure on pages 38 through 40 for procedures used to resolve any dispute which results from a medical necessity determination by Blue Cross' Review Center.)

The cost of copying and mailing medical records required for Blue Cross to review its determination is the responsibility of the person or entity requesting the review.

Medicare Denied Claims

1. **Notice of Claim Denial**

   This Plan supplements the benefits paid by Medicare. If a medical claim has been denied by Medicare, the supplemental payment through this Plan will also be denied, as secondary payment by this Plan is dependent upon Medicare's primary payment. Blue Cross will notify the Plan Member of such denial in writing. The Blue Cross notice shall contain the reason for the denial.

2. **Claim Denial due to Medicare Denial**

   You may appeal the Medicare determination with Medicare if the Medicare claim is denied. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you. If, after the appeal process is completed, you receive notification from Medicare that the claim has been paid, this Plan will pay any covered supplemental benefits.

Claim Denials Under Your Benefits Beyond Medicare or Vision Care Benefits

1. **Notice of Claim Denial**

   In the event any claim for benefits is denied, in whole or in part, Blue Cross shall notify the Plan Member of such denial in writing. The notice shall contain specific reasons for such denial and an explanation of the Plan's review and appeal procedure.

2. **Objection to Claim Processing or Denial**

   An aggrieved Plan Member may object by writing to Blue Cross' Customer Service Department within sixty (60) days of the discovery of any act, error, or omission with regard to a properly submitted claim; or within sixty (60) days of receipt of a notice of claim denial. The objection must set forth all reasons in support of the proposition that an act, error, or omission occurred.

3. **Time Limits for Response to Objection**

   Blue Cross will acknowledge receipt of a complaint by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days. If the case involves an imminent threat to the Member's health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of the grievance will be expedited.

   If Blue Cross affirms the denial or fails to respond within thirty (30) days after receiving the request for review and the Member still objects to an act, error, or omission as stated above, the Member may proceed to item 4 on page 37.

MEDICAL CLAIMS APPEAL PROCEDURE

4. Request for Reconsideration

If the Plan Member is not satisfied with the response to the initial inquiry, he or she may request reconsideration within sixty (60) days of receiving notice of Blue Cross' response. The request should be submitted in writing to the Customer Service Department. Any additional information that would affect the decision should be included. Blue Cross of California will acknowledge receipt of a reconsideration request by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days.

5. Request for Administrative Review

If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 43.

6. Objection to Denial of Experimental or Investigative Treatment

If Benefits Beyond Medicare medical services are denied because Blue Cross determines that they are experimental or investigational, an independent external review may be requested. You may request an independent review of a coverage decision for services that have been denied as being experimental or investigational if: (1) you have a terminal condition; (2) your physician certifies that standard therapies have been ineffective or would be inappropriate; and (3) either your physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or you or your physician have requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies. You will be notified of the opportunity to request this review when services are denied.

UTILIZATION REVIEW APPEAL PROCEDURE

This appeal procedure applies only to utilization review conducted for this Plan's Benefits Beyond Medicare (see pages 12 through 14). You may appeal any Medicare determination with Medicare. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you.

Blue Cross' Review Center may render a determination on whether or not a particular medical service is medically necessary at any of the following three stages:

1. Before services are rendered (prospective utilization review); or

2. During the rendering of services (concurrent utilization review); or

3. After services are rendered (retrospective utilization review).

If a Plan Member, treating provider, or facility disagrees with the Review Center's determination at any of these stages, they have the right to state that disagreement and request a re-review by the Review Center. The Review Center may refer certain prospective review determinations directly to CalPERS for its final administrative determination.

The cost of copying and mailing medical records required for the Review Center to review its determination is the responsibility of the person or entity requesting the review.

Prospective and Concurrent Utilization Review Decisions

The following procedures apply to reviews of determinations made prior to or during the time medical services are rendered:

Step 1: Reconsiderations

If the Review Center does not certify a requested medical service, the Plan Member, treating provider, or facility may request a reconsideration review by a Review Center physician advisor. This request must be made within thirty (30) days of receipt of the initial notification of noncertification. This request may be made orally by calling 1-800-451-6780 or by a written request sent to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;

- information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;

- information about how proposed treatment impacts or affects functional capabilities or medical stability; or

- information about changes in health status.

The review will be handled in the following manner:

- After reviewing all medical information received, the Review Center physician will discuss the proposed or ongoing treatment with the treating physician by telephone.

- The physician advisor will inform the treating physician whether the noncertification will be overturned or upheld.

- Written confirmation of the decision will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's noncertification is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second level of review, or Appeal, by a different physician advisor.

The Appeal process will follow the same procedures as in Step 1 above.

The Member, treating provider, or facility must request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request may be initiated orally but must be immediately followed by a written request sent to the above address.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

Retrospective Utilization Review Decisions

The following procedures apply to reviews of determinations made after services have been rendered:

Step 1: Reconsiderations

If the Review Center has not approved a request for a medical service that has already been received, the Plan Member, treating provider, or facility may request a reconsideration review by a Review Center physician advisor. This request for review must be made within thirty (30) days after receiving the noncertification and submitted in writing to:

Blue Cross of California
P.O. Box 60007
Los Angeles, CA 90060-0007

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;

- information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;

- information about how the treatment impacts or affects functional capabilities or medical stability; or

- information about changes in health status.

The review will be handled in the following manner:

- After reviewing all medical records received, a Review Center physician advisor will review the case and make a determination.
- Written confirmation of the decision will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's noncertification is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second-level review, or Appeal, by a different physician advisor.

The Plan Member, treating provider, or facility may only request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request must be submitted in writing to the same address as in Step 1 above.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

The review will be handled in the following manner:

- A different Review Center physician advisor will review the medical records received, with any additional information that may be submitted, and make a determination.
- Written confirmation of the decision will be issued to the Member and provider(s) within thirty 30 days of receipt of any additional medical records that may be required.

Request for Administrative Review

Following a prospective, concurrent, or retrospective noncertification, if the Plan Member or the Plan Member's provider continues to contest the Review Center's determination after pursuing the matter through the Review Center's Appeal procedure, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure found on page 43 of this booklet.

Objection to Denial of Experimental or Investigative Treatment

If services are denied because the Blue Cross Review Center determines that they are experimental or Investigational, an independent external review may be requested. You may request an independent review of a coverage decision for services that have been denied as being experimental or investigational if:

- You have a terminal condition;
- Your physician certifies that standard therapies have been ineffective or would be inappropriate; and
- Either your physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or you or your physician have requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies.

You will be notified of the opportunity to request this review when services are denied.

PRESCRIPTION DRUG APPEAL PROCEDURE

1. Denial of a Drug Requiring Approval Through Coverage Management Programs

You may request an appeal within one-hundred eighty (180) days from the postmark date of Caremark's notice of Initial Benefit Denial. Appeals should be directed to:

Prescription Claim Appeals MC109
Caremark Inc.
P.O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-443-1172

If you are dissatisfied with the determination made by Caremark, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter by following the procedure set forth on page 43.

2. Waiver of Non-Preferred Brand Copayment based on Medical Necessity

You may request a waiver of the Non-Preferred Brand copayment based on medical necessity through Caremark's formal appeals process by completing the following:

a. Obtain a letter from your physician that clearly identifies medical necessity for the non-preferred product vs. the preferred products or available generic alternatives.

   Important: In order to establish medical necessity, your physician must provide supporting documentation demonstrating that the preferred products and/or available generic alternatives are contraindicated or that you have tried them without clinical success.

b. Obtain any supporting medical records, test results, etc. to support your appeal.

c. Include the above with your written request for a waiver and submit to:

   Prescription Claim Appeals MC109
   Caremark Inc.
   P.O. Box 52084
   Phoenix, AZ 85072-2084
   Fax: 1-866-443-1172

Caremark's clinical staff will carefully review your waiver request, and you will be notified in writing of the outcome. If the waiver request is approved, the Non-Preferred Brand copayment will be waived, and you will be charged the Medically Necessary Non-Preferred Brand copayment for that specific non-preferred prescription in the future. Failure to establish a supportable medical need for a Non-Preferred Brand-Name Medication will result in denial of the waiver request.

If you are dissatisfied with the determination made by Caremark, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter using the procedure set forth on page 43.

The Plan reserves the right to periodically re-evaluate the medical necessity of the waiver of the Non-Preferred Brand copayment. As part of this review, you may be required to submit information from your physician to support the continued medical necessity of the Non-Preferred Brand drug. Failure to timely submit this documentation can result in repeal of the waiver of the Non-Preferred Brand copayment, and you will be charged the applicable Non-Preferred Brand copayment.

3. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for prescription drugs are not payable when first submitted to Caremark. If Caremark determines that a claim is not payable in accordance with the terms of the Plan, Caremark will notify the Plan Member in writing explaining the reason(s) for nonpayment.

PRESCRIPTION DRUG APPEAL PROCEDURE

If the claim has erroneous or missing data that may be needed to properly process the claim, the Member may be asked to resubmit the claim with complete information to Caremark. If after resubmission, the claim is determined to be payable in whole or in part, Caremark will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, Caremark will inform the Plan Member in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the determination made by Caremark, you may request a final administrative review from CalPERS within thirty (30) days using the procedure set forth on page 43.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

If the Plan Member remains dissatisfied after the appeal procedures of the appropriate third-party administrator have been exhausted, the Member may appeal to CalPERS. This appeal must be submitted in writing to CalPERS within thirty (30) days from the postmark date of the administrator's final determination.

The appeal must be mailed to:

CalPERS Office of Employer and Member Health Services
Appeals Coordinator — PERSCare Health Plan
P.O. Box 942714
Sacramento, CA 94229-2714

The appeal must set forth the facts and the law upon which the appeal is based. The time limit may be extended an additional thirty (30) days if good cause is shown; however, in no event will an appeal be accepted more than sixty (60) days after the postmark date of the Plan's final administrative determination.

Examples of what may be appealed include, but are not limited to:
-- Failure to properly pay incurred expenses.
-- Denial of approval for covered services.

Examples of what may not be appealed include, but are not limited to:
-- Medical malpractice.
-- Denial of services and benefits specifically excluded from coverage.

If CalPERS accepts the appeal, the following procedures apply.

1. Administrative Review

The Plan Member may present information or arguments in writing to support his or her position. CalPERS staff will attempt to resolve or address the Member's concern(s) in writing within thirty (30) days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

If the dispute remains unresolved following the Administrative Review process, the matter may proceed through the administrative hearing process. These hearings are conducted in accordance with the Administrative Procedure Act (Government Code Section 11500 et seq.). These hearings are formal legal proceedings presided over by an Administrative Law Judge (ALJ), and Plan Members unrepresented by an attorney should become familiar with this law and its requirements if they choose to appeal to this level.

3. Appeal Beyond Administrative Process

Upon exhaustion of the appeal process outlined above, if a Member is still dissatisfied with the outcome, he or she may appeal to the courts.

Civil legal remedies may not be commenced until the Plan Member has complied with these administrative procedures.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

Summary of Process and Rights of Plan Members

- **Right to records, generally.** The Plan Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.

- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.

- **Attorney Representation.** At any stage of the appeal proceedings, the Plan Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.

- **Right to experts and consultants.** At any stage of the proceedings, the Plan Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon the Plan must be served at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

MONTHLY RATES

Type of Enrollment	Enrollment Code	Cost
Insured Only	2791	$ 347.20
Insured and One Dependent	2792	$ 694.40
Insured and Two or More Dependents	2793	$ 1,041.60

State Employees and Annuitants. The rates shown above are effective January 1, 2006, and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change. Any such change will be accomplished by the State Controller or affected retirement system without action on your part. For current contract information, contact the Health Benefits Officer at your employing agency or retirement system.

Public Agency Employees and Annuitants. The rates shown above are effective January 1, 2006, and will be reduced by the amount your public agency contributes toward the cost of your health benefits plan. This amount varies among public agencies. For assistance in calculating your net cost, contact the Health Benefits Officer at your agency or retirement system.

Rate Change. The CalPERS Board of Administration reserves the right to change the rates set forth above, in its sole discretion, upon sixty (60) days' written notice to Plan subscribers.

DEFINITIONS

Act – the Public Employees' Medical and Hospital Care Act (Part 5, Division 5, Title 2 of the Government Code of the State of California).

Administrator –

1. denotes CalPERS as the global administrator of the Plan through the Self-Funded Health Plans Unit of the Office of Employer and Member Health Services of CalPERS, also referred to as "the Plan"; and

2. denotes entities under contract with CalPERS to administer the Plan, also known as "third-party administrators" or "administrative service organizations."

Allowable Amount – the Blue Cross of California Allowance (as defined below) for the service(s) rendered, or the provider's Billed Charge, whichever is less. The Blue Cross of California Allowance is:

1. the amount Blue Cross of California has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as Blue Cross of California's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

2. such other amount as the Preferred Provider and Blue Cross of California have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount Blue Cross of California determines is appropriate considering the particular circumstances and the services rendered.

Annuitant – defined in accordance with the definition currently in effect in the Act and Regulations.

Appeal – refers to the Member's right to request review of decisions relating to the Member's rights under the Plan. The term includes all of the following: the internal review by Blue Cross and the Pharmacy Benefit Administrator, sometimes referred to as a Plan grievance procedure; the Plan's final administrative review by CalPERS; the fair hearing accorded by statute; and any administrative and judicial review thereof.

Balance Billing – a request for payment by a provider to a Member for the difference between Blue Cross of California's Allowable Amount and the Billed Charges.

Billed Charges – the amount the provider actually charges for services provided to a Member.

Blue Cross – the claims administrator responsible for administering medical benefits and providing utilization review services under this Plan. As used in this booklet, the term "Blue Cross" shall be used to refer to both Blue Cross of California and BC Life & Health Insurance Company.

Board – the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Brand–Name Medication (Brand-Name Drug) – a drug which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Calendar Year – a period commencing at 12:01 a.m. on January 1 and terminating at 12 midnight Pacific Standard Time on December 31 of the same year.

Close Relative – the spouse, domestic partner, child, brother, sister, or parent of a subscriber or family member.

Contract Period – the period of time from January 1, 2006, through December 31, 2006.

Custodial Care – care provided either in the home or in a facility primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of illness or accidental injury. Custodial care includes, but is not limited to, help in walking, bathing, dressing, and feeding (including the use of some feeding tubes not requiring skilled supervision); preparation of special diets; and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

DEFINITIONS

Disability – an injury, an illness (including a nervous or mental disorder), or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one disability;
2. all illnesses existing simultaneously which are due to the same or related causes will be considered one disability;
3. if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Drug – a prescribed drug approved by the Federal Food and Drug Administration for general use by the public. For the purposes of this Evidence of Coverage, insulin will be considered a Prescription Drug.

Employee – is defined in accordance with the definition currently in effect in the Act and Regulations.

Employer – is defined in accordance with the definition currently in effect in the Act and Regulations.

Experimental or Investigational – any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Services which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational. Any issue as to whether a protocol, procedure, practice, medical theory, or treatment is experimental or investigational will be resolved by Blue Cross, which will have full discretion to make such determination on behalf of the Plan and its participants.

Family Member – an employee's or annuitant's lawful spouse and any unmarried child under age twenty-three (23), including an adopted child, a stepchild, or recognized natural child who lives with the employee or annuitant in a regular parent-child relationship. It also includes an unmarried child under age twenty-three (23) who is economically dependent upon the employee or annuitant while there exists a parent-child relationship, or is dependent upon the employee or annuitant for medical support by reason of a court order. It also includes an unmarried child over age twenty-three (23) who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age twenty-three (23). In addition, a family member shall include a domestic partner as defined in Section 22770 of the Act.

FDA – Food and Drug Administration.

Generic Medication (Generic Drug) – a Prescription Drug manufactured and distributed after the patent of the original Brand-Name Medication has expired. The generic drug must have the same active ingredient, strength and dosage form as its Brand-Name Medication counterpart. A generic drug costs less than a Brand-Name Medication.

Health Professional – dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; acupuncturist; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; physician assistant; registered nurse; a nurse practitioner and/or nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

Home Health Agencies – home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare.

Incentivized Copayment Structure – Members may receive any covered drug with copayment differentials between a generic medication, Preferred brand-name medication, and Non-Preferred brand-name medication.

Incurred Charge – a charge shall be deemed "incurred" on the date the particular service or supply is provided or obtained.

DEFINITIONS

Infusion Center – Any location, licensed according to state and local laws, in which medically necessary intravenous prescription drugs are administered.

Inpatient – an individual who has been admitted to a hospital as a registered acute bed patient (overnight) and who is receiving services that could not be provided on an outpatient basis, under the direction of a physician.

Maintenance Medications – Drugs that do not require frequent dosage adjustments, which are usually prescribed to treat a long-term condition, such as birth control, or a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days.

Medically Necessary – services or supplies the Plan determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or the convenience of your physician or another provider*;* and
5. The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an inpatient is needed due to the kind of services you are receiving or the severity of your condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

   NOTE: The Plan will accept Medicare's determination of medical necessity for services covered by Medicare.

Medicare – refers to the programs of medical care coverage set forth in Title XVIII of the federal Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Medicare Limiting Amount – refers to a federally mandated maximum amount a provider can charge a Member for covered services if the provider does not accept Medicare assignment. This amount cannot exceed fifteen percent (15%) more than Medicare's approved amount.

Member – See Plan Member.

Non-Participating Pharmacy – a pharmacy which has not agreed to Caremark's terms and conditions as a Participating Pharmacy. Members may visit the Caremark Web site at www.caremark.com, or contact Caremark's Customer Service at 1-866-999-7377 to locate a Participating Pharmacy.

Non-Preferred (Non-Formulary) Brand-Name Medication – Medications not listed on your printed Caremark Preferred Drug List. If you would like to request a copy of Caremark's Preferred Drug List, please visit the Caremark Web site at www.caremark.com or contact Caremark Customer Service at 1-866-999-7377. Medications that are recognized as Non-Preferred and that are covered under your Plan will require the highest (third tier) copayment.

Non-Preferred Provider (Non-PPO) – a group of physicians, hospitals or other health professionals that (1) do not have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) do not participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be non-PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories, and home infusion therapy providers.

Open Enrollment Period – a period of time established by the CalPERS Board of Administration during which eligible employees and annuitants may enroll in a health benefits plan, add family members, or change their enrollment from one health benefits plan to another without any additional requirements.

Over-the-Counter Drugs (OTC) – a drug product that does not require a prescription under federal or state law. PERSCare pharmacy program does not cover OTC products, with the exception of insulin.

Participating Pharmacy – a pharmacy which is under an agreement with Caremark to provide prescription drug services to Plan Members. Members may visit the Caremark Web site at www.caremark.com, or contact Caremark's Customer Service at 1-866-999-7377 to locate a Participating Pharmacy.

DEFINITIONS

Pharmacy – a licensed facility for the purpose of dispensing prescription medications.

Physician – a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Physician Member – a licensed physician who has contracted with Blue Cross of California to furnish services and to accept Blue Cross of California's payment, plus applicable deductibles and copayments, as payment in full for covered services.

Plan – means PERSCare Supplement to Original Medicare Plan. PERSCare is a self-funded health plan established and administered by CalPERS (the plan administrator and insurer) through contracts with third-party administrators: Blue Cross and Caremark.

Plan Member – any employee, annuitant, or family member enrolled in the PERSCare Supplement to Original Medicare Plan.

Precertification (precertified) – the Plan's requirement for advance authorization of certain services to assess the medical necessity, efficiency and/or appropriateness of health care services or treatment plans. This term does not include the determination of eligibility for coverage or the payment of benefits under the Plan.

Preferred Brand-Name Medication – A medication found on Caremark's Preferred Drug List and evaluated based on the following criteria: safety, side effects, drug-to-drug interactions, and cost effectiveness. If you would like to request a copy of Caremark's Preferred Drug List, please visit Caremark's Web site at www.caremark.com or contact Caremark Customer Service at 1-866-999-7377.

Preferred Drug List – A list of medications that are more cost effective and offer equal or greater therapeutic value than the other medications in the same drug category. The Caremark Pharmacy and Therapeutics Committee conducts a rigorous clinical analysis to evaluate and select each Preferred Drug List medication for safety, side effects, drug-to-drug interactions and cost effectiveness. The Preferred product must (1) meet participant's treatment needs, (2) be clinically safe relative to other drugs with the same indication(s) and therapeutic action(s), (3) be effective for FDA approved indications, (4) have therapeutic merit compared to other effective drug therapies, and (5) promote appropriate drug use.

Preferred Provider (PPO) – a group of physicians, hospitals or other health professionals that (1) have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories and home infusion therapy providers.

Prescription – a written order issued by a licensed prescriber for the purpose of dispensing a Drug.

Prescription Drugs – all drugs which under federal or state law require the written prescription of a physician, dentist, podiatrist, or osteopath; insulin; hypodermic needles and syringes if prescribed by a physician for use with a covered drug; glucose test strips; and such other drugs and items, if any, not set forth as an exclusion.

Prescription Drug Negotiated Rate – the rate that the Pharmacy Benefit Administrator has negotiated with Participating Pharmacies under a Participating Pharmacy Agreement for Prescription Drug Covered Expense. Participating Pharmacies have agreed to charge Members no more than the Prescription Drug Negotiated Rate. It is also the rate which the Pharmacy Benefit Administrator's Mail Service Program has agreed to accept as payment in full for mail order Prescription Drugs. In addition, if medications are purchased at a Non-Participating Pharmacy, it is the maximum allowable rate for reimbursement.

Prescription Legend Drug – any medicinal substance, the label of which is required, under the Federal Food, Drug and Cosmetic Act, to bear the legend "Caution: Federal laws prohibit dispensing without a prescription."

Prescription Order – the request for each separate drug or medication by a physician and each authorized refill of such request.

DEFINITIONS

Psychiatric Care – psychoanalysis, psychotherapy, counseling or other care most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor to treat a nervous or mental disorder, or to treat mental or emotional problems associated with illness or injury.

Regulations – the Public Employees' Medical and Hospital Care Act Regulations as adopted by the CalPERS Board of Administration and set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations.

Services – medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Nursing Facility – a facility that is:

1. licensed to operate in accordance with state and local laws pertaining to institutions identified as such;

2. listed as a skilled nursing facility by the American Hospital Association and accredited by the Joint Commission on Accreditation of Healthcare Organizations and related facilities; or

3. recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States Government pursuant to the Medicare Act.

Specialty or Biotech drugs – These drugs are very expensive therapies prescribed to treat specific chronic conditions such as multiple sclerosis, hemophilia, or growth hormone deficiency. Specialty and biotech drugs are often self-injectable or infused medications, but can also be oral therapies.

Subscriber – the person enrolled who is responsible for payment of premiums to PERSCare, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan.

Total Disability –

1. with respect to an employee or person otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage.

2. with respect to an annuitant or a family member, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage.

United States – all the states, District of Columbia, Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

FOR YOUR INFORMATION

Organ Donation

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

Long-Term Care Program

Your PERSCare health plan has strict limits on the long-term care services it provides. The Long-Term Care Program offered by CalPERS provides coverage for the extended care you could need due to a chronic disease, frailty of old age, or serious accident. It covers help with activities of daily living, such as bathing eating and dressing. It also provides supervision and support for people with cognitive impairments such as Alzheimer's disease. Long-term care can be needed at any age.

The CalPERS Long-Term Care Program is not part of the PERSCare health plan. If you want long-term care protection, you must purchase it separately. Please contact the CalPERS Long-Term Care Program at 1-800-338-2244 if you are interested in long-term care coverage.

Health Insurance Portability and Accountability Act (HIPAA) Information

CalPERS and its plan administrators comply with the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations that have been adopted under it. Your privacy rights under HIPAA are detailed in CalPERS' Notice of Privacy Practices (NOPP) which is mailed annually to each subscriber as part of the annual open enrollment mailing. In addition, the current NOPP is always available on CalPERS' Web site at www.calpers.ca.gov. If you have any questions regarding your rights under HIPAA, please contact the CalPERS HIPAA coordinator at (888) CalPERS (225-7377). If you are outside of the United States, you should contact the operator in the country you are in to assist you in making the call.

Office of Health Policy and Plan Administration
Self-Funded Health Plans
California Public Employees' Retirement System
PER-0106-SP1

PERSCare